DOCUMENT RESUME

ED 195 915 CG 014 870

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TITLE A Framework for the Analysis of Social Service Program Data.
PUB DATE 80
NOTE 26p.

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Administrator Guides; *Classification; Data Analysis; *Data Collection; *Delivery Systems; Health Services; Information Processing; Models; *Needs Assessment; Older Adults; Planning; *Program Evaluation; *Social Services

ABSTRACT

Relevant conceptual frameworks must guide data collection and analysis if data are to be useful to service program planners and administrators. Such frameworks are increasingly important in the systematic assessment of the total array of services in a planning region. This paper describes a two-dimensional classification matrix developed in relation to health and social services for older persons with a potential applicability to other service systems. The first dimension, level of competence, is outlined as five areas of behavioral functioning: (1) life maintenance; (2) perception-cognition; (3) self-maintenance; (4) effectance; and (5) social role. The second dimension, level of independence, is presented as defining a continuum of living arrangements that represent the level of need for support. This model suggests that, by using this system, services can be simultaneously differentiated according to the levels of competence and independence of those served. The utility of this framework for organizing service data is demonstrated through its application to information collected on services for the elderly in one location. Additionally, the potential of this framework as a tool in the planning process is discussed, and areas needing further development are identified. (Author/NRB)

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A FRAMEWORK FOR THE ANALYSIS OF SOCIAL SERVICE PROGRAM DATA

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1980

CG 014870

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A FRAMEWORK FOR THE ANALYSIS OF SOCIAL SERVICE PROGRAM DATA

by

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It is, by now, a truism that modern program planners and administrators must base their decisions on sound empirical data. A concommitant increase in public responsibility for service programs and decrease in available public dollars has created a widespread demand for accountability of those programs to the tax-paying public. The professionalism and good intentions of service providers are no longer sufficient assurance that their programs are worth the cost; quantitative evidence must also be offered to back up their claims.

The tasks created by this demand for empirical planning go beyond the simple collection of available facts and figures, however. Sufficient awareness of the needs for accountability now exists that considerable data is routinely collected from the direct service through the administrative level. Additionally, needs assessments have become commonplace and census data are becoming more responsive to the needs of the human service establishment. In many cases, in fact, a potential data overload exists if one compiles all that which is available.

If program data is to be useful, it must be amenable to analysis which is tied to utilization. The existence of large amounts of information does not guarantee that the most relevant figures are included nor that those which have been collected will be analyzed in a way which is optimal for answering critical service delivery question. For data to be useful to planners and administrators, relevant conceptual frameworks must guide its collection as well as its analysis.

One area in which such frameworks are increasingly important involves the need to systematically assess the total array of services in a planning region. There has been a move in recent years away from categorical approaches to planning and funding which focus on specific problems to human services approaches in which a population is considered in terms of its total array of problems and needs (Attkisson and Borskowski, 1978). In the field of aging, for example, planning responsibilities are divided according to geographic heirarchy. At each of the planning levels, attention is given to the overall well-being of the elderly population and attempts are made not only to support and coordinate the wide array of health and social services used by older people, but also to influence many broader public policies which impact on their lives. Such an approach requires that planners be able to consider the full range of potential human needs and their relations to each other. In short, there is a need for a classification system that can cover the universe of existing and potential services and divide those services into meaningful categories.

This paper describes a classification matrix which was developed in relation to health and social services for older persons, but which is potentially applicable to other service systems. The utility of the framework for organizaing service data is demonstrated by applying it to information collected on services for the elderly in one Midwestern town. The potential of this framework as a tool in the planning process is then discussed, and the areas in which it needs to be further developed are identified.

The Classification Matrix

The goal of human services is often identified as maintenance of the well-being of individuals in society (e.g. Meyer, 1976). More complex definitions specify that certain minimal levels of well-being are necessary in various areas of functioning (Kahn, 1967 and 1969). These minimal levels of well-being must be differentially defined for each specific behavioral functioning supported, and well-being in some areas (e.g. health, economic security) may be necessary before other areas can be effectively addressed (Schlonsky, 1970).

From this perspective, the most useful approach to classification focuses on the areas of need which supportive inputs might address. It is necessary to allow for varying types and intensities of support within each area of need. Additionally, the taxonomy should be able to account for all potential service functions, whether now in existence or not, regardless of variations in their delivery format, and whether provided informally or by formal organizations. These considerations led to the development of a two-dimensional classification matrix which defined the range of adult behavioral functioning on one axis (competencies) and levels of independence on the other. The resulting taxonomy (Golant and McCaslin, 1979) is presented in Figure 1 and is described in greater detail below.

The first dimension, level of competence, is a modification of a scheme developed by Lawton (1972) which follows a living systems approach. Areas of functioning are heirarchically arranged, beginning with the most basic (life and health maintenance) and proceeding through perception-cognition, self-maintenance, and effectance to social role which connects the individual to the next level of organization, the human group. Thus, the dimension of competence represents the full range of behaviors which make up normal adult functioning and, therefore, the range of behavioral deficits for which services might be provided. The five areas of behavioral functioning were defined as follows:

A. Life Maintenance and Health: Lawton's functional areas of "life maintenance" and "functional health" have been combined owing to the expected difficulty of differentiating services that address these two. The combined behaviors contribute to the maintenance of the biological survival and functioning of the human body. It is the lowest level of individual functioning with its simplest behavior manifestations (e.g., breathing) defining the existence of life. The most complex levels (e.g., athletic prowess) represent the maximum development of biological capacities. Functions between the extremes refer to states of relative health and behaviors necessary for their maintenance and improvement.

B. Preception-cognition: At its simplest levels, this category includes behaviors present in the earliest stages of human development, such as sensation, perception, and orientation, while the more complex behaviors represent the development of the highest levels of symbolic thinking, problem-solving, and abstracting skills.

C. Self-maintenance: Lawton differentiates between "physical" and "instrumental self-maintenance" behaviors. Physical self-maintenance behaviors are "genetically early, relate exclusively to the body, and are apt to regress only when impairment at higher levels is gross" (Lawton, 1972, p. 130). Dressing, grooming, eating, bathing, and toileting are included in this category. Instrumental self-maintenance, on the other hand, includes more complex and less body-oriented behaviors, such as using

the telephone, cooking, doing laundry, cleaning the house, taking medicine, and handling money. The behavioral functions in this self-maintenance area are often referred to as "activities of daily living." Because the ultimate purpose is service classification, these two levels are viewed as sufficiently similar to be combined into a single functional category of self-maintenance. Services in this area have proliferated in recent years, and instrumental and physical self-maintenance behaviors are often addressed by the same services. For example, both home health aides and homemakers provide services at each of these levels, and the distinctions between their tasks are sometimes unclear.

D. Effectance: The first three functional areas in Lawton's framework are related primarily to mastery of the most basic needs of the individual, as suggested by Maslow's (1962) identification of the primary needs of survival and security. Once a person is no longer preoccupied with achieving these, s/he becomes free to engage in mastery of activities aimed at fulfilling higher order needs, such as Maslow's belongingness, self-esteem, and self-actualization. A demonstration of these higher levels of functioning is the emergence of effectance behaviors--actions directed toward exploring and seeking variation in the environment as an end in itself (White, 1959). Engagement in activities such as spectator pasttimes, taking walks, recreational pursuits, education programs, and pursuing individual hobbies and interests are included here.

E. Social Role: These highest order behaviors are identified as social role functions, and range from sensory and casual interpersonal contacts and relationships to parenthood and creative leadership. Defined as the most complex level of individual behavioral functioning, social role competence links the individual to the next level of organization, the human group.

The second dimension, Level of Independence, was adapted from the work of Tobin, Davidson, and Sack (1976). It also follows a continuum from "institutional services or their equivalents" at the lowest end, through "services for the comparatively well elderly" at the high end. (These will be referred to as Institutional, Preventive, and Well-Elderly services, respectively.) This dimension is meant to define a continuum of living arrangements ranging from those in which the individual has complete control over his/her social situation, to those in which s/he has little or no control. "Social situation" is defined as the individual's relationship with the people, activities, material culture, and value orientations that are found in his/her living arrangements (Sherif, 1967). Level of Independence, then, represents the general level of need for support of the population or person being addressed.

Thus, in this classification scheme, services are simultaneously differentiated according to the levels of competence and independence of the older people they support. The categorizations of competence and independence are combined in a two-dimensional matrix, resulting in fifteen cells in which a specific service might be classified. It should be noted that services are not differentiated beyond the level of the individual matrix cell. That is, services classified within a cell are considered functionally equivalent.

Using the Matrix With Community Data

This classification system was used to guide the analysis of data on health and social services relevant to older people in Evanston, Illinois, a Midwestern town of 80,000 persons, sixteen percent of whom are aged 60

and over. Although it is an inner suburb in a large metropolitan area, this town operates as a fairly autonomous, self-contained entity for planning purposes and is generally thought of as a "service rich" environment.

In order to determine which human services would be included in the analysis, the service system of a community was viewed as a set of outputs or products. These outputs were conceptualized as potential resource products. No initial assumptions were made concerning the utility of the outputs, that is, how well or efficiently the service was performing its function.

Three criteria had to be met for a service output to be included in the sample: (1) it had to be formally organized and publicly identifiable as a service provider (2) it had to currently serve older persons either as its primary consumer group (age-segregated clientele), or as one of several population consumer sub-groups (age-integrated clientele); and (3) it had to be located in the community, or be located or administered outside its boundaries but identified by community leaders as a resource utilized by the community's older residents. Given these criteria, 119 services were identified including both public and private non-profit agencies, proprietary enterprises, public entitlement programs (county, state, and federal and private professionals,) even though substantial differences characterized their organization, administration, and funding structure.

Two fundamental considerations guided the construction of variables to describe these community services. First, the variable should provide the basis for effectively evaluating the potential of the services as resources--that is, as products that successfully meet the needs of older residents. Second, the data required to measure such a set of variables should be largely available without the data collection process taking an excessive amount of cost or time.

Information was obtained for fifteen measures of the structural attributes and the availability of the service output units. These are briefly defined below. (For more detailed descriptions, see Golant & McCaslin, 1979b).

A. Category of Service: Based on the functional classification scheme described earlier, each service output unit was categorized according to the level of individual behavioral functioning and the level of independence it addressed.

B. Absolute Location: Census tract and block units as defined by the U.S. Bureau of the Census were utilized to locate the major local offices of the services within Evanston. Services located outside of Evanston were coded as either "inside Chicago," or "in neighboring suburbs".

C. Relative Location: The number of walking blocks between each service unit office location (shortest route) and the nearest of three major business districts were calculated.

D. Location of Actual Service Delivery: Three locational groupings were distinguished according to mode of service delivery; services provided at a fixed location, services provided at variable locations, and home delivered services.

E. Cost of Services to Consumer; Lowest Income Group Served: Services were described according to their likelihood of serving older persons with different levels of income, categorized as: low income elderly, moderate-income elderly, and high income elderly. This determination was based on the constraints imposed by the source of funding for the service.

F. Cost of Service to Consumer; Eligibility Restrictions: Also based on consideration of the funding source, services were described according

to whether their funding structure made them available to all elderly or restricted their provision to groups of elderly at certain income levels.

G. Auspices: Service units were described as either public or private. This variable differed from the "cost" classifications in that it categorized the major funding sources of the agency or organization rather than that of the specific service output unit.

H. Age-mix of clients served: Service units were described as either: age-integrated (available to all adults without distinction according to age), or age-segregated (available only or predominantly for persons defined as elderly).

I. Percentage of total clients who were elderly: The number of elderly served monthly by the service unit was divided by the total number of persons served each month.

J. Date service started: The year in which the service output unit addressing the needs of older persons was started was recorded.

K. "Transfer" versus "other" services: Service outputs were categorized as transfer programs if they were purposively developed public programs that enabled persons to purchase goods and services at below market prices (i.e., government subsidization programs). All other services were placed in the "other" category.

L. Size of service output unit; Number of staff: The number of direct service staff available within each service unit in an average month was recorded in full-time equivalents. Top level administrators, clerical staff, maintenance, and kitchen staff were excluded from this measure.

M. Size of service output unit; Total clients served per month: The total number of persons of all ages receiving services from the staff in an average month was recorded. For hospitals and nursing homes, bed capacity was used for this measure.

N. Size of service output unit; Number of old people served per month: Number of persons aged sixty and over (or as closely defined by the service provider) served in an average month was recorded.

O. Labor intensiveness of service output unit: Total clients served per month was divided by total number of staff to give a client-staff ratio.

Analyzing Service Delivery Patterns

Data obtained for each of the fifteen measures was examined within the classification matrix. First, those measures which consistently followed the two dimensions of the classification matrix were identified. The matrix can be seen as a two dimensional hierarchy which defines the urgency of needs and concommitantly, the complexity of skill required to meet those needs (see figure 2). For purposes of this study, that would mean that needs addressed by Institutional and Preventive Services could be thought of as more urgent than those addressed by Well Elderly Services, and that Institutional and Preventive Services could be expected to require more complex skills on the part of the provider than would Well Elderly Services. To the extent that this conceptualization was valid, certain of the measures would be expected to follow the same pattern as that defined by the matrix.

This was, indeed, the case. The labor intensiveness of a service, for example, varied directly with the position of a cell in the matrix, indicating that the complexity of skill required to meet needs does indeed increase as the needs as defined by the matrix becomes more basic. Number

of staff also increased in the same direction, indicating that the more complex services were well developed in this community. Blocks from the central business district followed an inverse pattern in which services which were most critical for survival were located least conveniently. This is in keeping with the notion of "central place theory" (Christaller, 1966) which holds that people will use whatever resources are necessary to obtain critically needed services, while less urgent services have to be conveniently located to facilitate their use by potential consumers. Finally, age of services was consistently higher as their urgency/complexity increased. The oldest programs were predominantly traditional, medically-oriented approaches to caring for the elderly when they became too debilitated to survive independently. These would necessarily be complex services supporting urgent needs. The patterns found for these measures are summarized in Figure 2.

Data on other measures followed patterns which did not parallel the matrix, and these were examined next. Three indices were constructed to facilitate analyses of the patterns of these variables: existing magnitude of services, expansion potential, and "traditional" versus "social utilities" service structure. Each index was constructed by ranking the average values for selected measures within the classification matrix. These ranks were then averaged within each cell so that a summary ranking was available to order the fifteen cells. Cells which ranked close to each other at the high and low ends on each index were considered to form a grouping.

The index for existing magnitude of services was formed using data on number of existing services classified within each cell, average number of clients per month, and average number of elderly clients. Expansion potential consisted of ranking for average number of staff and average client/staff ratio. (This index assumed that the more staff a service had and the fewer clients it was able to serve per staff member, the less chance there was of that agency expanding its services to reach new clients.) The index of traditional versus social utilities services was derived from measures which reflected these differing delivery patterns: mean year services were begun, mean blocks from business districts, percent available to low-income groups, percent public, and percent age-segregated.

These indices were combined on the basis of their convergence. All cells which grouped with one another on at least two of the three indices were considered part of the same summative cluster: Cells which appeared in a cluster on only one index were included in the grouping but defined as borderline cases. Three distinct clusters of services were defined by this method: Traditional Services, New Wave Services, and Undeveloped Services. These are summarized in Figure 3.

Traditional Services: These services had the largest impact on the community in terms of number of persons reached, accounting for sixty-seven percent of all client contacts reported and fifty-nine percent of elderly client contacts. They were old, established agencies and institutions and represented traditional, residual approaches to serving people. The philosophy guiding such services held that a community's responsibility to support its members (at any age) did not begin until the individual was too debilitated to care for him/herself, usually for reasons such as poor health or old age which were "acts of God" rather than the result of personal failure. This responsibility was found to be carried largely by the private sector, originally an institutionalized form of personal charity. Even within this charity system, a person was apparently expected

to pay for his/her care whenever possible so they were not designed to be available to low-income groups. These services were highly skilled and were well staffed but, due to their labor intensiveness, were considered unlikely to expand without a large investment of additional resources.

New Wave Services: These services represented a smaller but still substantial segment of the service environment, accounting for thirty-two percent of clients and thirty-nine percent of elderly in this sample. They were recent additions to the service system, ninety-one percent having begun after 1969 and fifty-one percent after 1972. They followed a more modern "social utilities" approach to serving people in which higher order life stage needs were seen as appropriate to community support. This responsibility was found to be more often carried directly by the public sector. Efforts were apparently made to assure that services were geographically and financially accessible to those who needed them. Such services usually require a low level of skill from the provider and, relatively few staff were involved in their delivery. There was, therefore, considerable room to expand these programs to meet community needs and a small addition of staff could accomplish a large expansion of service potential.

Undeveloped Services: This cluster of cells was identified as an area in which formal programs seldom existed. Some services of this type did exist in the study community and were included in the formation of the summative indices, Traditional and New Wave Services. One can assume that some supports of this sort were available to older persons. For example residential facilities by definition must support these higher order behaviors. It is also likely that informal networks were meeting these needs, especially at a preventive level. For example, churches may have attended to their frail elderly members' needs for stimulation and socialization by facilitating their involvement in parish activities. However, such supports were seldom formalized to the extent that service providers and clients could be identified.

Synthesis

Evanston services exhibited a pattern of growth and change that is likely typical of other communities in this country. Viewed within the framework of the classification matrix, one can see that the growth of the service system into new areas has progressed in a fairly systematic manner to encompass successively higher order needs. Traditional services, addressing the lowest levels of human functioning, were still most prominent and can be expected to remain to meet the needs of very frail elderly. But a new set of services appeared to be developing as well which supported older persons' ability to continue to function at higher levels as their circumstances changed with retirement and increasing age. These latter programs also represented greater direct involvement of the public sector in service delivery. Although quite new, they already accounted for a sizeable proportion of services received by the elderly and they could expand further with minimal resource input. Reflecting a contemporary philosophy of community responsibility and possibly the changing expectations of cohorts of elderly over time, it was likely that they would continue to grow.

A few points of unevenness were evident in this growth pattern: Well Elderly life maintenance services and Preventive perception-cognition

supports seem to have been "skipped over" to some extent. The former primarily medical services remained largely in the hands of individual private practitioners--not surprising given the conservative bent of the professional organizations which have influenced this area. Perception-cognition (e.g., counseling) services probably represent a special case, due to the pervasive stigma attached to mental health services. Institutional mental health services were well developed, caring for persons whose mental capacities are so diminished as to preclude other options. At the other end of the independence continuum, innovative approaches such as information and referral had been developed to assist well elderly with limited problem-solving difficulties in non-stigmatizing ways. Preventive programs, however, were still largely traditionally psychotherapeutic and might be under-used in part because their users were popularly thought to be "weak" or "crazy". These less developed service areas required additional attention from those who plan for the service needs of elderly in the community, but they did not detract from the overall progression to newer perspectives on human needs.

The next service areas to be developed in this progression were also evident. Those identified as Undeveloped Services were a continuation of the direction service growth was already headed. They would require new ways of operationalizing preventive philosophies of community responsibility and assessment of needs that had largely been ignored in the past. Yet attention to the importance of adequate levels of socialization and stimulation in forestalling deterioration at more basic levels was clearly needed if the wholeness of the individual was to be addressed.

A clear pattern of growth was identified in Evanston's service system relative to older persons. This growth followed a logical progession in which traditional, residually-defined supports remain necessary while, at the same time, social utility approaches had begun to develop in large numbers. These supports for higher order functions could be expected to grow and to extend to less independent populations of elderly than those on which they were focused. As of the time that these data were gathered, the service system was clearly moving from a stance of limited assistance for the "deserving" to a holistic view of the individual as a part of the community throughout his/her life.

Implications for the Planning Process

From a planning perspective, a classification scheme such as this can be used in several ways. It provides a framework for thinking about service needs, it serves as a guide in defining existing services and gaps, and it helps to suggest patterns in service. The staff of the city of Evanston has had some experience using the tool in each of these ways and can project some possibilities for use in communities just beginning to organize and plan their services for the elderly.

The latest regulations for the Older Americans Act require Area Agencies on Aging to name community focal points that will be responsible for planning at the community level. To the extent possible, these focal points will be required to ensure that the entire range of services is available for the needs of the population in their community. With this new ruling, many communities are naming commissions, or other forms of planning bodies. While the composition varies from one town or region to another, several structural forms are typical. Most have a small professional or semi-professional staff. This staff may or may not have a background in planning. More often, their background is services to the

elderly and/or recreation. Most of these agencies are directed by an appointed board of lay people or lay people and service providers. These organizations will become the initial planning layer supplying information to Area Agencies, for their planning and for pyramiding of planning up to the federal level.

These local agencies, then, must know what services exist in their community and what are the gaps. They will need to ascertain patterns in order to most effectively plan for funding. The classification tool can provide them with a framework with which to begin to explore their own turf. The concept of a "service gap" clearly implies some idea of what should be. There has to be a conceptual model in order to decide something is missing; a way of looking at possibilities, not just realities. While less obvious, the term "service" is also definable only if there is a model of what service is.

The schema presented here provides a set of assumptions that define services and gaps in terms of the whole person. It can be used to look at need-defined services, rather than professional/traditional-defined services. A community surveying services for the first time can choose to broaden its perspective and broaden the uses of the matrix by completing a chart with generic service types (see Figure 4). For instance, taken in its broadest sense, the life-maintenance column of the chart should include life's fundamentals--food, air and shelter. In the original study and development of the classification system, the d[illegible]gners chose to define services in a social service, formalized, traditional way. But one is not limited to this definition. The more limited system used in development is easier for most people. Broadening the definitions can be frustrating because one has to look at items we take for granted and at services which are difficult or impossible to change. However, the broader perspective helps break thinking patterns that limit planners to repetition of old systems, patterns that favor one group, or patterns that are no longer appropriate. A "generic" use forces holistic thinking and allows groups to make the most appropriate definition of limits for planning in their area.

The generic chart will assist the planners to decide where local agencies fit. Does anybody supply food? Counseling? Many different charts can be done and looked at from a variety of different perspectives. One local planning groups may want to plot funding sources. Who funds which services? How many services are there in each category? How stable are the funds?

The staff may want to use charts in another way. It is important to note differences in perspective among individuals and/or types of individuals. What agencies do professionals think of when they complete a chart? What about non-professionals, how do they complete their charts? These attitudinal differences can be made clear by looking at charts done by individuals.

The charts, then, have many values and many different uses. What problems are there? First, the terminology is difficult and can be unclear to the layperson, not to mention many of the professionals. What constitutes self-maintenance to one, may be life-maintenance to another. At this stage of development of the tool, too much time should not be spent resolving differences. Instead, more information needs to be gathered on where the differences occur and how definitions differ. Again, looking at series of individual charts will help to sharpen definitions for the future.

Second, what do the patterns mean? For example, looking at several different localities with very different patterns of service (from agency rich Evanston to a sparsely served rural area) a pattern seems to recur. Matrix cells in which the most services are found tend to fall on the diagonal running from the lower left (life maintenance services for the institutionalized) to the upper right (effectance/social role services for the Well-Elderly) (See Figure 5). This diagonal seems to be indicative of traditional, acceptable government activity. It encompasses nursing homes, counseling services, subsidization programs, and recreational programs. This pattern is found in all the community areas reviewed.

A different pattern appears in the service rich communities. It seems to be a "new, new wave". Here the diagonal goes in the opposite direction. It runs from the upper left hand corner of the matrix (life effectance programs for the Well-Elderly) to the lower right (effectance/social role for the Institutionalized). (See Figure 6). This secondary pattern may be the result of professional pressure for services. These are the preventive services for the health and the add-on programs that provide quality of life services for those with complex needs.

It may be, that with more opportunities to see the differences between professionals and community people as they complete charts individually, patterns will emerge in which professionals have a tendency to focus vertically--on service types. Community people, in contrast, would likely focus on types of people and stress the horizontal dimensions.

But, all of this is conjecture and requires testing. The results will really make it possible to look at patterns and to make some predictions about changes that are happening. However, the testing of these hypotheses is dependent on careful definition of services and service use. For example, consider the problem of service components. Is the lower right hand section of the chart usually empty or nearly so because there are no services to add role development and culture to the lives of the institutionalized, or is it because these services are such an integral part of the nursing home itself that they are overlooked?

Finally, because the tool does encourage inclusion of such a variety of types of programs, it is difficult to determine the meaning of trends. For instance, in northeast Cook County, Illinois, the following services are new in the past two years:

Telephone Health Information
Exercise Group
Health Maintenance Organization Program for Elderly
Emergency Housing Bureau
Two Hospices
Home Care for the Dying
An Activity Center
Association for Older Women
Budget Counseling
Senior Companions
Ombudsman
Local Emergency Food Vouchers
Visiting Nurse Homemaker Service
Nursing Home Advocate
Senior Citizen Camp
Transportation to Nutrition Site
Foster Home Program
Two Commissions on Aging
New Recreation Program
Foster Grandparents
Four Senior Housing Buildings
Congregate Housing Units
Housing Counseling

Obviously, a number of these are small and simple projects that do not require large amounts of funding and could be established relatively quickly. They probably reflect funding decisions made in the past year. Some have very stable funding bases, others do not. But, right in the

middle of this pattern are a whole group of new housing projects for the elderly. These reflect decisions that were made four to ten years ago. At the very least, the planner, in using the charts and in interpreting them, is best advised not to simplify them too much.

While the uses detailed here are likely to be the most frequent, the tool can be used far more specifically. For example, a Health Systems Agency Committee, deleted the line for Institutionalized and used the two remaining (Well-Elderly and Preventive) to make certain they were including all needed services as they inventoried their area for home care agencies. They too began with a generic listing of types that should be available. Next, they listed agencies which provided the services, doing different charts for different areas of the Agency Planning Area. The results will not only make their directory inclusive, they can also direct review decisions as new services ask to establish themselves, and they can assist the agency in defining what comprehensive home care programs they need to provide or make available.

Conclusion

A classification of health and social services has been presented and its usefulness both for studying existing community services and for guiding the planning process has been discussed. Initial efforts in which this schema has been used have been fruitful, but it is anticipated that refinements would increase its utility. It is hoped that this framework can be adapted for use in a broad range of situations and in combination with a variety of research and planning methods.

The potential usefulness of the classification matrix lies in its ability to define and organize the complete spectrum of human needs which services might be provided to address. The increasing complexity of the human service system and the broadening mandate of planning agencies demand such tools. It is time to move beyond simple enumeration of existing services and to begin to systematically consider the value of each service in relation to the total network. The framework presented here is meant to facilitate that process.

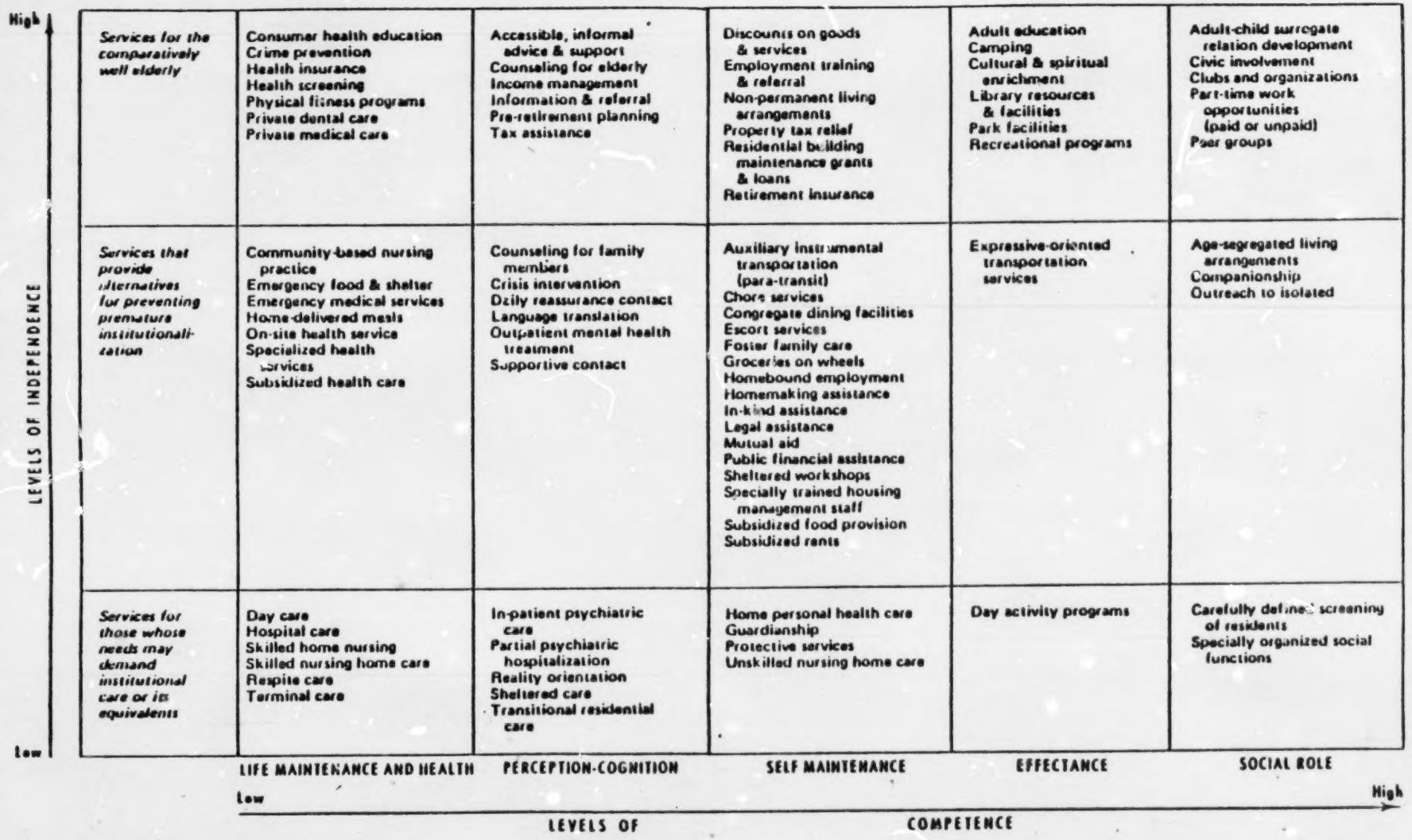

Figure 1. Services Classified According to Levels of Competence and Independence Addressed

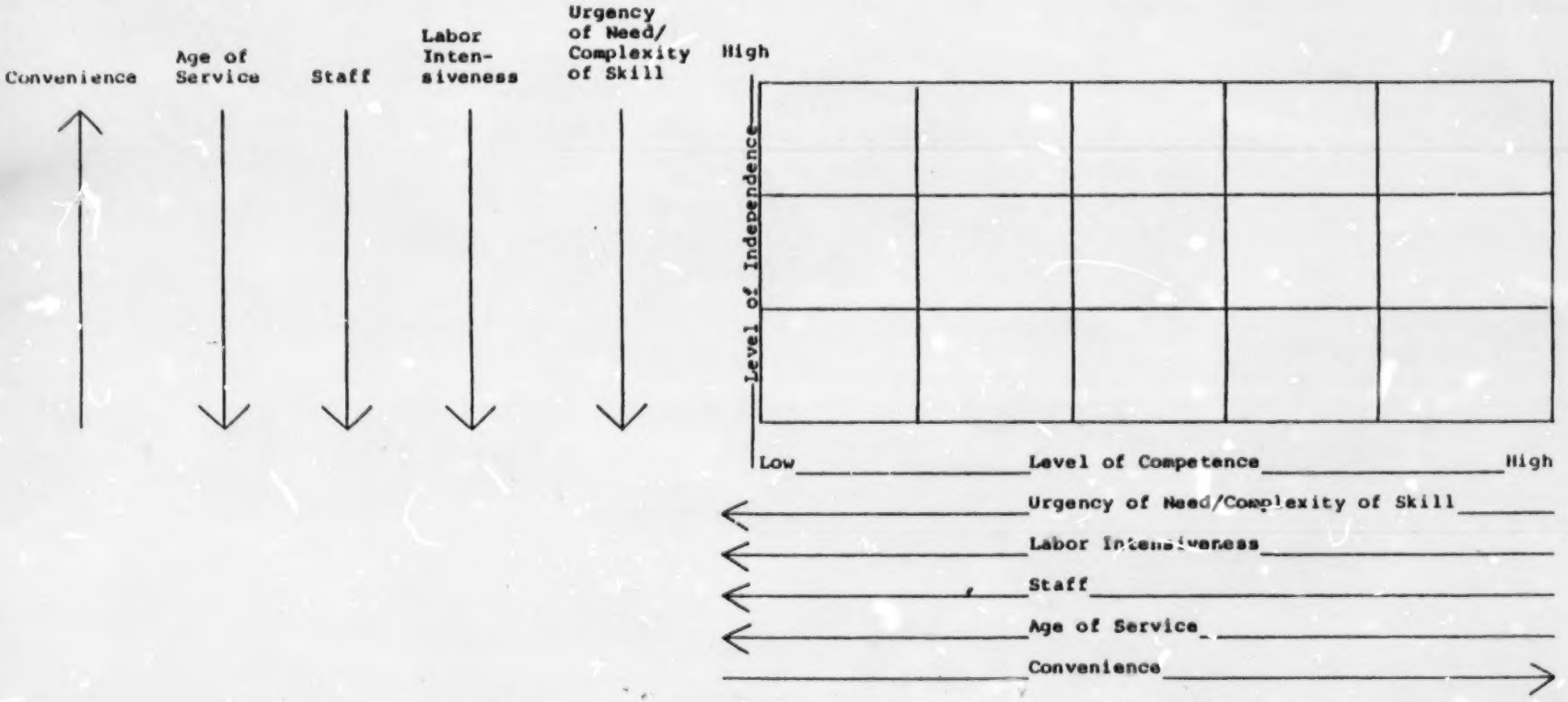

Figure 2. Variables Which Follow the Hierarchical Ordering of the Matrix

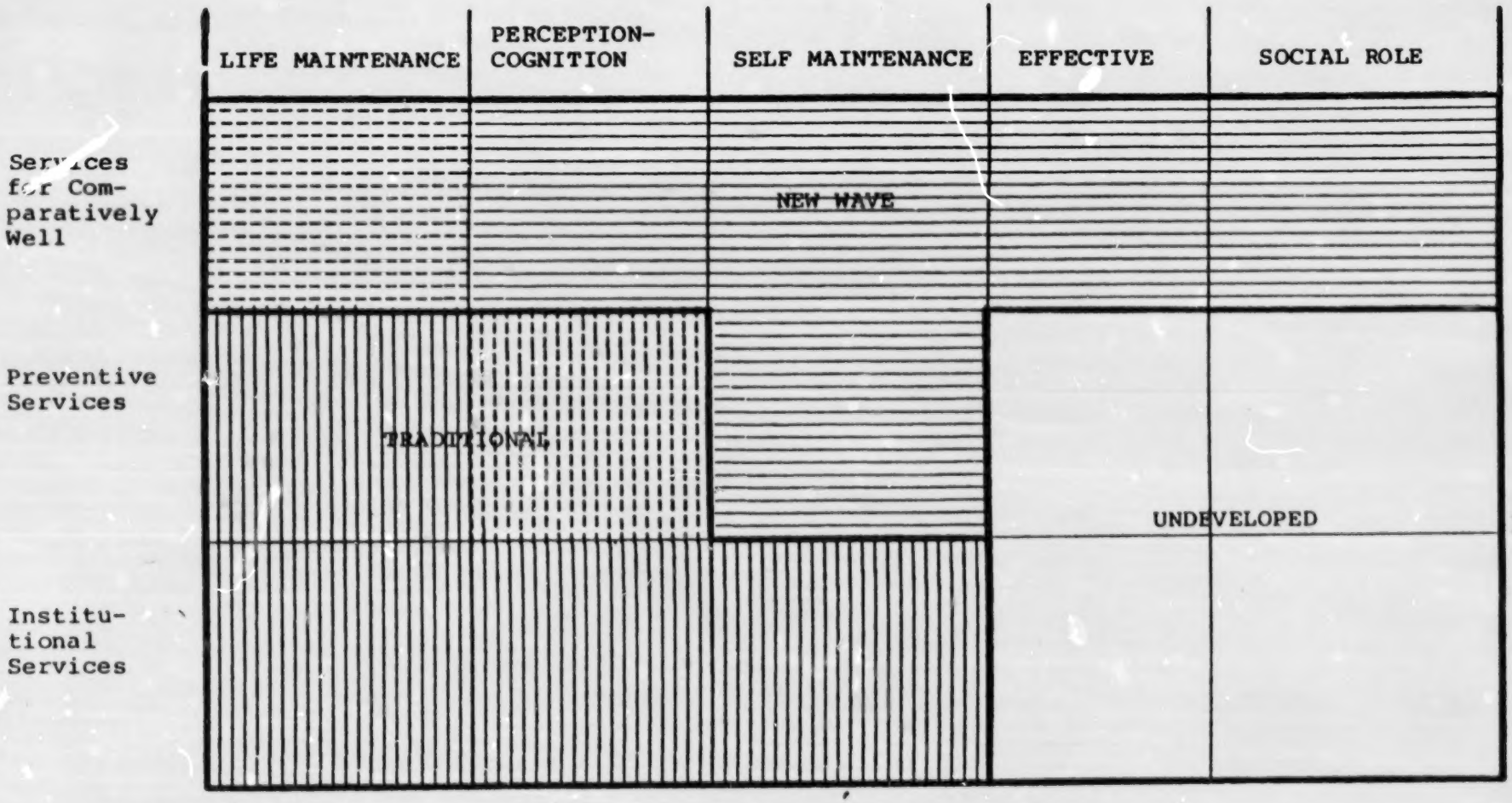

Figure 3. Summative Service Clusters

	LIFE MAINTENANCE	PERCEPTION-COGNITION	SELF MAINTENANCE	EFFECTANCE	SOCIAL ROLE
Services for the Comparatively Well Elderly	Food Shelter Health Screening	Information/ referral Family counseling Assisting completing forms	Employment	Cultural programs Recreational programs Religious	
Preventive Services	Subsidies Special Diets Medical Care	Counseling Crisis intervention Reality orientation	Subsidies Transportation Rehabilitation Sheltered workshops Specialized housing	Transportation Friendly visitors	
Institutional Services	Hospitals Nursing Homes Terminal Care	Reality orientation Counseling	Day Care Rehabilitation	Specialized living centers	

Generic Chart as completed by one person. Note placement of day care between categories, repitition of several services for different types of people.

FIGURE 4

	LIFE MAINTENANCE	PERCEPTION-COGNITION	SELF MAINTENANCE	EFFECTANCE	SOCIAL ROLE
Services for the Comparatively Well Elderly	Tuberculosis screening	Information/ referral**		Senior Center** Library Park activities Foster Grandparents**	
Preventive Services	Hospitals Nutrition Sites**	Counseling** Crisis Service**	Transportation** Home Delivered Meals** Subsidies Homemakers**	Senior Housing**	
Institutional Services	Nursing Homes Home Health**	Counseling**	Day Care**		

Chart showing services in a rural area. New services are marked with double asterisk and underlined. As in previous chart, last two columns are combined.

FIGURE 5

	LIFE MAINTENANCE	PERCEPTION-COGNITION	SELF MAINTENANCE	EFFECTANCE	SOCIAL ROLE
Services for the Comparatively Well Elderly	Telephone line for medical information Exercise group Special HMO program for elderly	Activity Center Organization for older women Budget counseling		Senior Citizen Camp Park District Recreation Program Foster Grandparents	
Preventive Serivces	Emergency housing program	Senior Companions Advocate for the homebound	Housing counseling Emergency food voucher program	Senior Housing Project 1 Senior Housing Project 2 Senior Housing Project 3 Senior Housing Project 4	
Institutional Services	Hospice Home Care for terminally ill		Visiting Nurse home care Nursing home ombudsman	Day Care Program Workshop rehab. for nursing home residents Congregte Housing Project	

Chart shows new services in the past two years in a suburban area.

FIGURE 6

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